DISENGAGEMENT FOR CIVILIAN MEDICAL CARE

NAVMEDCOMINST 6320.3B

(Date)

From: _____ / _____
(Physician's Name and Clinical Service)

_____
(Name and Address of Facility)

To: _____ / _____
(Patient's Name) (Responsible Family Member's Name)

Procedure/Services Required by Patient: _____

_____

Patient disengaged:

To receive care under: _____
(Program, If Known)

To receive care from: _____
(Health Care Provider/Source, If Known)

Disengagement: I understand that the above named facility does not have the capability to provide the services required by the patient named hereon. I understand that the Navy will not be responsible for the cost of care obtained through this disengagement. The Navy has not recommended nor directed the patient named hereon to a particular physician or source of care. I acknowledge that I have been counseled concerning this disengagement and its possible cost-sharing provisions under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other programs that may be responsible for costs associated with this disengagement. I understand that I am to receive a copy of this statement.

Patient or Responsible Family
Member's Acknowledgement: _____
(Signature)

Patient's Name: _____ Status: _____
(Rank/Service/Dep/Ret)

Address: _____

SSN: _____ ID Card No: _____

Phone No: _____ ID Card Issue Date: _____

DEERS Check: _____ _____ ID Card Effective Date: _____
(Yes) (No)

ID Card Expiration Date: _____

DEERS Verifies Eligibility: _____ _____
(Yes) (No)

Counselor: _____ _____
(Signature) (Date)